QI Clinical Meeting
January 17, 2006
Meeting Minutes

Attendees: Sundin Applegate, Wendy Benz, Karen W. Burstein, Jacquilyn Cox, DeAnn Davies, Martha Frisby, Elaine Groppenbacher, Robin Blitz, Diane Lenz, Gloria Navarro-Valverde, Sharman Ober-Reynolds, Molly Parrott

MEETING ITEM	SPEAKER	DISCUSSION	ACTION ITEMS
Welcome	Jacquilyn Cox	Dr. Cox welcomed all the participants to the January meeting of the Quality Improvement Clinical Committee. The Committee members were provided with a packet of handouts.	
Introductions	Committee members	Each member introduced themselves to the group and provided a short background of their involvement with integrated services, quality improvement, and clinical development for children with special health care needs and their families.	
Review of Minutes of Previous Meeting	Committee members	The minutes were approved with no changes. Dr. Cox reminded the Committee that the Integrated Services for Children and Youth with Special Health Care Needs Task Force Survey (in their binder) is due by Friday, January 13th. They can mail or email the Survey back to her as it is accessible on our website.	Minutes accepted by Committee members.
Tasks of Quality Improvement Committee and Handouts		The "Committee Action Planning" template form was presented on screen for the committee members.	
	Dr. Cox	We are using a professional facilitator to assist us with the Task Force and she developed this worksheet. We have taken all the tasks outlined in the grant and divided them by tasks specific to our individual committees. In addition, the MCHB Performance Measures are included in your packet. We want to incorporate these performance measures into an outcome performance measure for each.	

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	Dr. Cox	One of the primary tasks of the QI Committee is to identify the screening instruments to be used in the medical home and to come up with ways to evaluate the medical home. An update on Medical Home was provided. Four sites will be selected. Two are traditional pediatric practices and two are school-based clinics. We will place a screener and a care coordinator in each site. The screener will screen for developmental delays, mental health issues, dental, transition issues, etc. The care coordinator would then take those people identified by the screener and confirmed by the physician, and find appropriate placement. The other major task is monitoring for the activity of Medical Home. Does having a care coordinator in the medical home improve treatment and access, etc to healthcare? The tasks as they exist now are, **1) Evaluate all data collection activities for appropriateness of instrumentation, analysis, implementation and interpretation.** That is inclusive of a selection of the instrumentation for the screener, as well as care coordinator. **2) Evaluate the effectiveness of youth and parent involvement**. They are using parents on most committees. **3) Establish specific performance measures to evaluate the progress of the grant**. That is the document that was given to us by MCHB (Appendix E: Program Specific Information). **4) Propose additional studies** and 5) **Train and encourage youth and parents on the "consumer-to-consumer" interviewing as a methodology for gathering client satisfaction data**. This coincides , if you recall, Larry Gallagher's (NAU) presentation in the last meeting. I don't think they are at the point of training people yet on this.	

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	Dr. Cox	The data collection proposed under the grant relates primarily to the Medical Home. And then to look at the functionality of these various committees. Dr. Cox reviewed the structure of the Task Force and the Committees that have formed thus far, as well as those that will be forming soon. All the committees have very specific tasks, which are described in the grant. The tasks of the QI Clinical Committee is to monitor that the committees are functioning the way they are supposed to, and completing the tasks designed for them.	
Committee Action Planning handout (#1)	Dr. Cox	Starting with task 1: Evaluate all data collection activities for appropriateness of instrumentation, analysis, implementation, and interpretation.	
	Dr. Robin Blitz, St. Joseph's Hospital	Who is creating the data collection activities?	
	Dr. Cox	To some degree, we are, but the other committees can also come up with additional ones. When this was written, it was meant more for the data collection activities around the Medical Home. But there are other big data collection activities alluded to by the other committees, such as Needs Assessment Surveys.	
	Dr. Blitz	Who is determining what developmental screening tools are being used?	
	Dr. Cox	At the moment we have the PEDS and Ages & Stages on the table. I lean towards the PEDS, but the practitioners really like Ages & Stages because they are used to it.	
	Dr. Blitz	Ages & Stages costs more money based on the paper flow, and it also counts on parents to do activities with their kids. I think people are used to it because AzEIP has used it for all these years. Both are good tools.	
	Dr. Cox	A screening instrument should be able to be delivered by a non-MD. And if you screen positive, and you could have a lot of	

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		false negatives in there, then an evaluation is done by a professional. If the doctor wants to use Ages & Stages at this point that will be considered diagnostic.	
	Dr. Blitz	The PEDS consists of 10 questions in multiple languages and it recognizes if parents have concerns about these different areas of development. There's research that shows, even if a parent has concerns about a child's behavior and it is appropriate for the parent to be concerned; it might not necessarily be in tuned to their age, but rather, if their language abilities are delayed or social skills are impaired.	
	Dr. Cox	How are they used in different cultures? We are going to have a fairly high percentage of families that are Hispanic in our school-based clinic.	
	Dr. Blitz	It has been standardized in Spanish and tested across the world. It is so easy to use. The parent is interviewed with the questions and it needs a parental caregiver there. It is easy to take. Less than 2 minutes to score. Anybody can be trained to give it and score it. ASQ is more difficult to score. What I like about PEDs is that it tells you what to do next, etc.	
	Dr. Cox	What is AHCCCS's experience? Have you gotten any PEDS in? When the data starts coming in, as to what you are going to do with it in relation to the EPSDT area?	
	Gloria Navarro-Valverde, AHCCCS	I don't think it has been set as if they will be joined or not. It will be evaluated and looked at. As far as I know, there's no word on if it will be matched to the EPSDT. It has been going back and forth as to if it will be included in the EPSDT form.	
		Flagstaff entered the meeting via video conferencing. Molly Parrott and Diane Lenz introduced themselves.	
	Diane Lenz, NAU Center on Disabilities	Diane advised us of Larry Gallagher's change in jobs. He is the new Chair of the Dept. of Education's *Specialty Services* at the College of Education at NAU. So he is in class today for the first day of classes.	
	Committee Members	The committee members introduced themselves once again for the benefit of the teleconferencing members.	

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	Dr. Cox	We are looking at the tasks of the QI Clinical committee and specifically the form "Committee Action Planning". We are currently talking about whether the PEDs is an adequate and appropriate screening instrument used in our Medical Home studies. We were asking Gloria about how AHCCCS is using the PEDs in relation to the EPSDT.	
	Gloria Navarro-Valverde, AHCCCS	There was talk about if the PEDs form will come with the EPSDT. I don't know yet. The EPSDT is done on the baby within 2 weeks then at one month.	
	Dr. Blitz	The EPSDT, for development screening, may list a couple milestones at that age, which has been proven not to be a good type of screening. More recently, it has been suggested to use a more standardized screening tool and that was one of the purposes of putting the PEDs as the standardized tool in that piece.	
	Wendy Benz, Raising Special Kids	Are you trying to identify what is being used now?	
	Dr. Cox	We are talking about using the instruments in our four Medical Home studies. Putting a screener and a care coordinator in there and the screener will screen for a multitude of things such as developmental delays which brought us to talking about PEDs. We will be talking about the other types of screening tools later but I wanted to get an idea from this committee on using the PEDs as an adequate screening tool. In this particular SBC that we are involved with, and received permission from, they do not see AHCCCS patients. They see many "undocumenteds". Every other place we will be going has a high proportion of AHCCCS patients, so they will have the EPSDT.	
	Dr. Cox	So if we went ahead with that, would anyone have a strong objection? Get the people trained on it and Gloria could help, since the training for the position is very comprehensive. Is that	

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		the usual way to train a screener? I don't know what the standard is for training people.	
	Dr. Sundin Applegate, ADHS-OCSHCN	It's web based, takes about an hour.	
	Dr. Blitz	When I was using it in my foster care clinic, it is very easy to teach and administer.	
	Dr. Applegate	And score?	
	Dr. Blitz	And score as well. I would get the scored form and go forward with the interpretation with the parents.	
	Dr. Cox	Every place I talked to is most comfortable with that. Get the scored form and implement according to their practice format.	
	Dr. Applegate	Currently, there is a push with AHCCCS to use the PEDS. See if it works and expand from there.	
	Dr. Blitz	Depending on what the results are from PEDS, the recommendation is to do the secondary screening. ASQ as a secondary screen at any age. Then to use the M-CHAT (autism screening tool) as a secondary screen for 18 months through 4 years of age.	
	Dr. Cox	What is the recommendation regarding frequency?	
	Dr. Blitz	At well child visits. On the scoring sheet, just one sheet per child. The scoring sheets have all the well child visits and their ages, you write down the result and what you did as a result of the screening test. Clear documentation that the child was screened and we did this, etc. I should have brought a PEDs pamphlet as it has a flow chart on the back of it that guides you on what to do next.	
	Molly Parrott, Flagstaff Community Partnership	Question was raised on the different screenings. Are you looking at gathering all these screening tools and have physicians, at the well child visit, go through every one of them?	
	Dr. Cox	This particular one I am asking about the periodicity, and the recommendation is every well child, but for some of the other instruments, it may not be appropriate.	

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	Molly Parrott, Flagstaff Community Partnership	Behavioral health just came out with a screening tool for the 0-5 populations. Looking at the paperwork sent, integrating behavioral health into a lot of this, seems to be appropriate but I am not sure if it is a piece of this discussion.	Dr. Blitz directed us to the website www.pedstest.com
	Dr. Cox	It will be. Mental health will be and is definitely a part of the screening process. We are on Task 1 from the Committee Action Planning form.	
	Dr. Blitz	I have done about 5 trainings throughout the state and I would come to Flagstaff if needed.	Dr. Blitz offered to train people in Flagstaff if appropriate
Autism Screening Tool	Sharman Ober-Reynolds, Southwest Autism Research & Resource Center	An autism-screening tool will determine children at risk at 12 months and will help nurses and practitioners. My understanding of PEDs is that it will bring up issues on autism. If the PEDs is what physicians use and is already available, it would be best to utilize. The template used in scoring is an involved process but a good tool.	Autism tool used at 18 to 24 months and up to 4 years for the secondary.
	Dr. Cox	It will still require training. Is SARRC doing training?	
	Dr. Blitz	It is not appropriate for school based, only if they are doing pre-school. M-chat training is involved as well. When I do my PEDs training, I go into M-chat at the end for interpretation and review.	Some school-based clinics see the entire family so we need to accommodate all ages.
	Dr. Karen Burstein, Southwest Institute	The electronic version integrates very well. It "ups" to M-CHAT. Parents can enter via computer.	Dr. Cox will look into the electronic versions. www.forepath.org
	Elaine Groppenbacher, ValueOptions	Ms. Groppenbacher raised concern that it's not a screener but a multiple developmental tool used as one component of screening. Not a standard screener, not a standard needs assessment but rather to gain access to presenting concerns. Discussion ensued regarding PEDs being inclusive for behavioral health and specific to parent input.	Dr. Blitz directed us to the Pediatric Symptom Checklist at the PSC pediatrics web site (DBP.org).

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			Dr. Groppenbacher stated ASQ, ASQSE for the young, TABs <<*or TAPS*>> for older.
	Dr. Cox	What do we use to screen non-verbal and as they grow up, what is used there?	Dr. Blitz mentioned that the Youth Self-Report Form is part of the Youth Behavior Checklist of the child and starts at 8 years. (Achenbach)
Mental Health and Substance Abuse Issues	Dr. Blitz	Other concerns are anxiety, depression. What's the screening for substance abuse?	
	Ms. Groppenbacher	We can get the one page screen for substance abuse that ValueOptions uses. Southwest Human Development has an early headstart program that was looking at using screeners. They may have something.	Dr. Burstein will send Dr. Cox information on the review on adolescent mental health based on the AZAAP recommendation. Dr. Applegate suggested Dr. Karla Birkholz, from Your Family Physician, for ARMA recommendations
		Dr. Burstein raised the question if it is IRB experimental. Dr. Cox also mentioned that it might not be adopted as a standard method.	Dr. Groppenbacher offered information as to another potential resource-the 12-22 year old adolescent substance abuse grant under behavioral health (Leticia D'Amore). Dr. Cox to follow-up internally to ADHS.
Dental Health Screening	Dr. Blitz	Dr. Blitz mentioned that the EPSDT could help with the initial information gathering. Dr. Cox raised questions as to what would they look at, use, and what would be reported by parents. Also, when would intervention be determined.	Gloria Navarro-Valverde stated that AHCCCS uses self-reporting most of the time.

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		Dr. Burstein stated that the Arizona School of Dentistry has a one-page screen process. Dr. Applegate voiced concern over if the screen was more of a prioritizing mechanism.	
	Deann Davies, Phoenix Children's Hospital	Raised the question of what age we would be looking at to screen. She mentioned that "bottle rot" can be screened early and then there is what is called "sippy cup rot". Dr. Blitz stated that there is participatory guidance that is done at the well-child checkup Ms. Ober-Reynolds stated that children with disorders are particularly hard to evaluate, or the parents are unduly frustrated for other reasons not yet diagnosed.	
	Dr. Blitz	There are transitional issues such as visual impairment, cranio problems and fetal alcohol syndrome.	
	Dr. Burstein	On the topic of transitional screening, Dr. Burstein stated that Tressia Shaw has a simple screen process of 6 questions. Such as "are you ready to do……." Dr. Burstein also mentioned that SWI has a longer one involving issues of independent living, getting a job, taking care of yourself. Dr. Cox was interested in knowing what age this would be initiated. Dr. Burstein informed her it was age 14.	
	Ms. Groppenbacher	Stated that with elementary age, IDEA (academic screening tool) can be used. Dr. Blitz said there is support for PEDs with a secondary screen for this age. Dr. Burstein stated that the data would be more descriptive.	

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		Dr. Blitz also mentioned that the specificity improves if used at the Parent Well Check. Dr. Applegate stated that it is the age range that may be most important in deciding which tool to use.	Gloria Navarro-Valverde stated that the EPSDT is used up to age 20 annually.
Academic Screening	Dr. Burstein	In regards to the academic screening for purposes of the Medical Home, it is not so much as if they are performing, but how they are performing. Dr. Blitz agreed and stated that it is also "does you child have trouble with…..". And sometimes, high functioning autism is never diagnosed.	Dr. Cox stated that there is a lot of collecting of information to do. She will look forward to any information that is sent email to her, and she will also try to find more electronic resources that the committee can benchmark off of.
Medical Home	Dr. Cox	Stated that she has just glimpsed briefly at the Cooley tool. Dr. Burstein said that it is currently the "gold standard" but it is long. The physician, parent and staff complete it. It would be an opportunity for screeners to get involved. She said that the PHP has a multi-year PIP based around Cooley and it is the best thing out there currently. We can benchmark off our pediatricians as they have an internal process (Jean McAllister). It is a self-report checklist. It asks if this is presently in your practice. If so, how are you doing. Dr. Applegate asked if it is a "practice assessment". Dr. Burstein replied yes, Cooley is, but centered on Medical Home. Dr. Cox asked how many practices were involved. Dr. Burstein mentioned that is was primarily pediatricians but did not have a number. Physicians are asked certain questions. If concerns were documented, then "how would they change their practice" to fit. Also "time to treatment" issues are addressed. Care Coordination was a big topic. Doctors would ask "what do you want us to do?" Time and money are the two biggest	Dr. Burstein will send Dr. Cox the self report checklist

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		drawbacks. Dr. Burstein stated that PHP and different models of disbursement will report back Dr. Blitz stated that pediatricians and family doctors will be reimbursed for this and they are happy about that.	
Committee Action Planning handout (#2)	Dr. Cox	Moving to number 2 of the Committee Action Planning handout, it is the goal to always have the parent at the screening. Also, with the youth that are participating, we want more than just a questionnaire.	
	Dr. Applegate	Suggested we look at the product and the outcome. A discussion ensued regarding if parent and youth get initial input and how are they involved. Dr. Blitz asked if they get paid and Dr. Cox informed her that they get paid for travel and time. Dr. Cox reiterated that the whole purpose of this grant is to engage parents and for them to give us their expertise.	Dr. Burstein stated that the Rockefeller Foundation did a wonderful study on leadership development. She will send this to Dr. Cox. Dr. Groppenbacher stated that she would send information she has from Portland State Behavioral Parent Professional Partnership.
	Diane Lenz, NAU, Center on Disabilities	Raised the question as to how did the people involve grow in this leadership development. What was the impact of parents? Dr. Cox stated that we have a stable parent base and will know how effective they are. Dr. Groppenbacher asked what was the measure of this involvement. The measure of the effectiveness of their participation versus what is the product we are coming up with and the impact of that. She stated that she has some informational resources on this and will send to Dr. Cox. What is faithfully done between clinician and the person. A 4-point	Dr. Groppenbacher will send Dr. Cox the information she has on the Scott Miller Outcome Reading Scale.

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		scale used in the mental health field, but the bulk of it is interaction.	
	Diane Lenz, NAU	It is participatory action research. Look at the recommendations made, the origination point and the activities and were the recommendations acted upon. The balance is delicate. Dr. Groppenbacher stated it was very much interactive. Family vs. professional.	
	Dr. Cox	Question was raised to Ms. DeAnn Davies from the Healthy Steps Program at Phoenix Children's Hospital as to the current youth involvement.	
	DeAnn Davies, Phoenix Children's Hospital	Stated that at Phoenix Children's Hospital, they have a group of children on the hospital Children's Advisory Council and it is currently being followed up on.	Ms. Davies advised Dr. Cox that Frank Ryder in Tucson is a good connect for resources. He has a youth involvement component.
	Dr. Cox	Dr. Cox raised a question to Dr. Burstein as to how Southwest Institute structured their youth council. Dr. Burstein stated that PAR (participatory action research) was one infrastructure used at Southwest Institute's with regards to the development of their youth council. How the individual changes across time, as in the Hall-Hord System of Change.	Dr. Burstein will forward information to Dr. Cox on the Hall-Hord System of Change measure and what benchmarks Southwest Institute used.
	Dr. Cox	Any other suggestions at this time? Ms. Davies pointed out to make it fun. And additionally, ask about family or marital discord. Dr. Blitz mentioned that when she sees a child, she always asks if there are any changes in the family. It is a standard closing question in her visits. Ms Frisby stated that there are also different parents involved at times.	Should we add family issue screeners (i.e., marital discord and post partum depression) and can they be used in the medical home?

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Closing		As time ran out for the scheduled time of the QI Clinical's January meeting, Dr. Cox advised the Committee to take the Committee Action Planning form and try to respond to tasks 3, 4, and 5 of the overall Goal which is "To oversee all data collection procedures, analysis, and report to the Task Force". She mentioned that we want to try and structure a way of quantifying our information to respond to where we are currently in our continuation.	Dr. Burstein will provide information on some benchmarks Southwest Institute used.
Next meeting		**Next meeting of the QI Clinical Committee is February 21, 2006 at the ADHS Bldg., 150 N. 18th Ave., Suite 345A at 1pm to 3pm.**	